RESTRICTION REQUEST

Purpose: This form is used for an individual's request to restrict use or disclosure of health information including for treatment, payment or health care operations, other than a request for confidential communications.

Please type or print neatly; we are not able to process incomplete or illegible forms.

DHMH Program Name: _____

Section A: Individual requesting restriction.

Last Name: First Name: MI:

Street Address: Apt#:

City: State: Zip:

Phone: (home) (work): Date of Birth: / /

Section B: To the Individual – Please read the following and complete the information requested.

You have the right to request that we restrict our use or disclosure of your health information, including for treatment, payment or our health care operations. We do not have to agree to your request; however if we do agree, our agreement must be in writing, and we will then restrict our use or disclosure of your health information as you request, except that we may, notwithstanding our agreement, use or disclose the restricted information in a medical emergency when the information is needed for your treatment, or when you authorize us in writing to use or disclose the information, or when the use or disclosure is required or authorized by law.

You may end the restriction at any time by notifying us in writing. We may end our agreement to restrict use or disclosure of your health information at any time by notifying you in writing. If you agree with our decision to end the restriction, your health information will no longer be subject to the restriction. If you disagree, our termination of the restriction will apply only to your health information that we receive after we gave you our notice terminating the restriction.

Please specify the health information, the use or disclosure of which you want to restrict:

Please state the restriction you want to apply to that health information:

SIGNATURE

I request DHMH restrict the use or disclosure of my health information as specified above. I understand that DHMH is not required to agree to my request. I understand that the requested restriction will not be in force unless and until DHMH informs me in writing that it has agreed to my request.

Signature: Date:

If a personal representative is making this request, please attach a copy of any document granting legal authority and complete the following:

Personal Representative's Name:

Relationship to Individual:

YOU ARE ENTITLED TO A COPY OF THIS REQUEST.

(LETTERHEAD)

DENIAL OF RESTRICTION REQUEST

(DATE):

(INDIVIDUAL'S NAME):
(INDIVIDUAL'S ADDRESS):

Dear (INDIVIDUAL):

We decline your request made on / / that we restrict our use or disclosure of your health information. This means that we will continue to use or disclose the health information that we create, receive or maintain about you in accordance with the Notice of Privacy Practices that we previously sent to you.

If you have any questions, please contact the undersigned.

Sincerely,

By: _____

(LETTERHEAD)

AGREEMENT TO RESTRICTION REQUEST

(DATE):

(INDIVIDUAL'S NAME):
(INDIVIDUAL'S ADDRESS):

Dear (INDIVIDUAL):

We agree to restrict our use of disclosure of your health information in accordance with your request dated on ____/____/____. We will not use or disclose the health information you identified in your request contrary to the restriction you requested as long as this agreement remains in effect, except we may use or disclose the restricted information in an appropriate medical emergency when the information is needed for your treatment, or when you authorize us in writing to use or disclose the information, or when the use or disclosure is required or authorized by law.

You may end this restriction agreement at any time by notifying us in writing. We may end this restriction agreement at any time by notifying you in writing. If you agree with our decision to end this restriction agreement, your health information will no longer be subject to the restriction. If you disagree, our termination of this restriction agreement will apply only to your health information that we receive after we gave our notice terminating this restriction agreement.

If you have questions, please contact the undersigned.

Sincerely,

By: _____

(LETTERHEAD)

NOTIFICATION OF RESTRICTION ON USE OR DISCLOSURE OF HEALTH INFORMATION TO BUSINESS ASSOCIATE

To: _____
Business Associate

From: _____
DHMH Program

On / / , DHMH agreed to a request from the individual named below to restrict our use or disclosure of the following health information:

The restriction that applies to the above health information is:

You must ensure that the above health information is neither used nor disclosed in violation of the above restriction. Should the restriction be modified or removed, we will notify you in writing. If you have questions, please contact the undersigned.

Sincerely,

_____ Date:_____

Individual Requesting Restriction:

Last Name: First Name: MI:

Street Address: Apt.#:

City: State: Zip:

Phone: (home) (work)

Date of Birth: / /